ment. This is unfortunate, since an orchidometer is of value in early recognition of macro-orchidism in fragile X mental retardation, in addition to the uses outlined by Dr Chapman. Can a medical supplier fill the void or must we continue to write to Professor Prader?

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Drug regimens and fasting Moslem patients

SIR,—This year the Islamic fast of Rosa in Ramadan started on 21 May and lasts for one month. Between the hours of sunrise and sunset the intake of food and drink and the use of medicines is prohibited—although drugs may be taken at the patient's own discretion for specific illnesses such as diabetes. There are over 1.5 million Moslems in the United Kingdom, so the medical treatment of an appreciable number of patients may be disrupted during this time.

Currently we are examining aspects of health education among Asian women. Although this survey is not complete, it is appropriate to convey a cautionary note about drug regimens during these few weeks of fasting. In our survey 44 unselected Moslem women were undergoing treatment from either their GP or the hospital outpatient department for a variety of ailments. Thirty seven of these women said they fasted in Ramadan, five did not fast, and two sometimes fasted. In the fasting group only seven patients said they continued to take their medicines at the prescribed times. The 30 patients who did not comply either missed doses (25 patients) or, more seriously, took all their medicines for that day in one single dose (5 patients). This latter practice is clearly potentially dangerous. Of those omitting doses, 18 took only one dose in either the morning or evening while seven patients took only two doses, one in early morning, the other in late evening, outside the fasting period.

Although our results are preliminary, they clearly highlight several possible dangers inherent in these approaches to fasting and drug taking. Firstly, the appropriate therapeutic concentration of drug is not maintained for the requisite period and will be exceeded in the patient who consumes a whole day's supply at once. Secondly, in this latter group the dangers of toxic reactions and drug interactions are greatly enhanced.

Clearly, doctors should be aware of the possibility of these practices among their Moslem patients during this time and, when appropriate, advise against omitting or combining doses in this way.

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The limited list: first month in a teaching hospital

SIR,—As well as affecting prescribing in general practice the limited list has also been introduced into hospital practice. We studied the effects of the list at this hospital during the first month of its implementation.

Since March 1985 pharmacists within the Nottingham Health Authority have been recording details of all "interventions" made by them in Nottingham hospitals over prescribing. These interventions included answers to telephone queries made to the drug information service by staff members, personal contact between the ward pharmacist and the pre-

scribing doctor, and telephone calls from the pharmacist to the prescriber to clarify possible errors on prescription forms. From 1 April a separate note was made of all interventions relating to the limited list. We compared the number of interventions made at the 1400 bed University Hospital during the month before and the first month after implementation of the limited list.

The pharmacists reviewed 17 940 individual items prescribed during March 1985 and intervened on 417 (2.3%) occasions. Between 1 and 30 April 1985 the pharmacy staff reviewed a further 16 354 individual prescription items and intervened on 299 occasions (1.8%). These interventions related to the limited list on 28 occasions (12% of the interventions made); there were six telephone queries for information and 22 prescriptions requiring clarification (table).

Details of limited list interventions made during April 1985

Type of intervention made by pharmacy	Outcome
Enquiries for information (n=6)	Appropriate reply given
Is the following still prescribable?	Dorbanex? Yes
	Colofac? Yes
	Diocetyl? Yes
	Librium? As chlordiazepoxide
How do I prescribe Distalgic?	As Co-proxamol
What is in Co-dydramol?	Ingredients told
Scripts for blacklisted items queried (n=22)	Prescription altered
Item prescribed (frequency):	
Laxatives	3 (Normacol, Senokot, Dulcolax)
Iron and Vitamins	5 (Orovite (2), Multivite, Ferrograd C, Lipoflavonoid)
Nasal drops	3 (Otrivine (2), Afrazine)
Sedatives and tranquilisers	5 (Flurazepam (2), Ativan, Libraxin, Clobazam)
Cough suppressants	1 (Actifed)
Mucolytics	1 (Mucodyne)
Analgesics	3 (DF118, Lobak, Solpadeine)
Antacids	1 (Aludrox)

Dr James A Grant and others described the effect of the limited list on general practitioners and a pharmacist during its first three weeks (27 April, p 1280). We believe the present study to be the first account of the effect of the list in a teaching hospital. We could not determine whether doctors had altered their prescribing habits as a result of implementing the list. The number of interventions made during April was small in relation to the total number of drugs prescribed in the hospital (1.8%); queries relating to the list accounted for only 12% of all the interventions made. It will be interesting to see whether this proportion decreases as doctors become more accustomed to the limitations imposed on their prescribing.

We thank Mr S Garner, Mrs J Joy, Mr N Jones, Mr R Wilson, and all the pharmacy staff at the University Hospital for cooperation in the collection of data.

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Trial of relaxation in reducing coronary risk

SIR,—The conclusions that Drs Chandra Patel and others draw from their trial of relaxation in reducing coronary risk (13 April, p 1103) surely must be open to considerable doubt.

Although undoubtedly statistically significant, a difference in blood pressure at four years between two groups of 145/90 mm Hg for the controls as against 140/85 mm Hg for the treated must, on the basis of existing epidemiological evidence, have debatable clinical significance in terms of coronary risk. Hopefully, the long awaited publication of

the report of the MRC working party on mild to moderate hypertension will resolve this.

Similarly, what are we to make of the statistically significant difference in electrocardiographic abnormalities between the two groups when we are told that electrocardiograms were not available on all subjects and when self reported cardiac morbidity did not differ significantly?

Even if the differences which they had shown to be statistically significantly different between the two groups were indeed important in terms of prognosis of cardiac risk, it would still be difficult to agree with the authors' conclusion that those variables had been influenced at four year follow up to any important degree by a regimen which only three out of 81 subjects were still following in the manner that its originators had intended. It would be helpful to know how many of the control group emulated the 73 members (90%) of the treatment group and "often or sometimes told themselves to calm down under pressure." This is claimed as a benefit of treatment but is hardly an unlikely response in the untreated population. Unfortunately the authors do not tell us the replies of the control group to the questionnaire.

All this seems to detract rather from the claim that in relaxation, "we may indeed have found a mass strategy suitable for primary prevention that is safe, cheap, effective and acceptable."

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* Dr Patel and Professor Marmot reply below.—
Ed, *BMJ*.

SIR,—We do not know to which figures Dr Salmon is referring. Over the four years we reported a net difference between treatment and control groups of 8.7 mm Hg systolic and 6.5 mm Hg diastolic. We calculated from Whitehall data that if the excess mortality risk associated with high blood pressure were reversible a reduction in the population mean pressure of 6 mm Hg diastolic would lead to a 15% reduction in the mortality from coronary heart disease and a 35% reduction in stroke mortality.¹ The "clinical significance" (Dr Salmon's phrase) is substantial.

But are the effects reversible? We shall soon know if the MRC mild hypertension trial² confirms the findings of the American hypertension detection and follow up study³ and the Australian trial showing that reduction in blood pressure of the magnitude we observed can reduce the rate of complications significantly. In addition, behavioural treatment may reduce complications through paths other than blood pressure or other conventional risk factors.

The missing electrocardiograms were related not to characteristics of the participants but to availability of electrocardiographs at only three of the four worksites where the study was conducted. It is interesting that subjective reports of disease, though more subject to biased reporting, were in the same direction. There were nine subjects out of 81 in the control group who had 18 cardiovascular "events," while five subjects out of 88 in the treated group had five "events."

Dr Salmon wonders how the treatment could have worked if most subjects were not strictly following the twice daily relaxation regimen. The treatment group had reported that they had incorporated relaxation into their daily lives. We did not ask this question of the controls. However, as we shall report, the control group responded less favourably to a number of questions on psychosocial health.

This study was not designed as a long term morbidity study. With the small numbers taking part, we had not expected to see an effect on